

Attachment 4
NOTIFICATION TO DMH
REGARDING PROVISION OF THERAPEUTIC BEHAVIORAL SERVICES

Child/Youth's Name _____

Social Security Number or Beneficiary Identification Number _____

Beginning Date of Therapeutic Behavioral Services _____

County/MHP Code or Name _____ Date _____

Form Completed by (Name) _____ Phone _____

Primary Residences for Child/Youth While Receiving TBS (Check All That Apply)

Family Home _____
Foster Home _____
Foster Family Agency _____
Children's Shelter _____
Group Home _____ specify RCL _____
Other Specify _____

Class Membership (Check One)

In RCL 12 or above _____
Being Considered for RCL 12 or above _____
One Psychiatric Hospitalization in Preceding 24 months _____
Previously received TBS while Class Member _____

Service Need (Check One)

To Prevent Placement in a Higher Level of Care _____
To Enable Transition to a Lower Level of Care _____

TBS Service Plan

Planned Average Hours of TBS per Week _____
Estimated # Weeks of TBS _____

Initial Information _____ OR Quarterly Update _____

SUBMIT THIS FORM within the first thirty days of service and every quarter thereafter to:

Nancy Mengebier
Department of Mental Health
1600 9th Street, Room 100
Sacramento, CA 95814
Phone (916) 654-3486

If form is handwritten, please make sure the handwriting is legible.